Claims Processing Policies and Procedures

BadgerCare Plus Coding Quick Reference

	Medicaid FFS	Security Health Plan BadgerCare Plus Claim Coding
1. Multiple surgery	100 percent/50/25/13 (sequencing of claims)	Modifier 51 100 percent/50/50/50,etc.
2. E & M New Patient	A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.	Follow MA guidelines.
3. Bi-laterals	1 code, 50 modifier at 150%	Follow MA guidelines.
4. Unusual service 22 modifier	Not recognized.	Follow MA guidelines.
5. Prolonged services and critical care	Only pay for 4 hours per date of service-manual review.	Manual review. Need physician notes.
6. Physician assistant (non-HPSA)	90% payment, bill under PA's number.	Follow MA guidelines.
7. Physician assistant (HPSA)	Payment the same as a physician.	Follow MA guidelines.
8. Surgical assist	Physician – 20% of the surgical fee type of service 8 Physician assistant – 80% of the 20%	Follow MA guidelines. Type of service not required.
9. Obstetric (OB) services	Use either the separate OB component procedure codes as they are performed or the appropriate global OB procedure code with the date of delivery as the date of service.	Follow MA guidelines. Notify Security Health Plan by letter of first date of visit or use MA codes for a no charge. Use the global code for complete care.
10. TMJ and splints	Paid if physician is a non-oral surgeon.	Paid if physician is a non-oral surgeon. Oral surgeons are paid by MA-FFS.
11. E & M on the same day as a procedure by the same provider	Deny E & M	Deny E & M unless a 25 modifier, then service is reviewed for payment. Submit notes.
12. Anesthesiologists	Bill modifier with anesthesia codes. Use modifiers when supervising.	Follow MA guidelines.
13. CRNA's	CRNA's will bill under their own number or name with an appropriate modifier. Use anesthesia CPT codes.	Follow MA guidelines.

Claims Processing Policies and Procedures

	Medicaid FFS	Security Health Plan BadgerCare Plus Claim Coding
14. DME rental purchase	DME is rented by the day. TOS – R (rental) P (purchased)	DME rented by the month or day. Modifier – RR (rental) Modifier – NU (new/purchased)
15. Professional component	ROS – Q, T, X, S, W	Modifier 26
16. Technical component	TOS-U	Modifier TC
17. Global X-ray*	TOS – 4, K, 5, 6, B	No modifier
18. Pre- and post-operative	Varying number of days.	Medicare guidelines.
19. Incidental surgery procedure	Minor procedures. Bundled in the major surgery.	Bundled/unbundled edits according to CMS guidelines.
20. Second opinions	Not required.	Not required.
21. Hysterectomy consent	Send to state. Waived if patient is postmenopausal or sterile.	Send to Security Health Plan. Follow MA guidelines.
22. Norplant (insertion and supply)	Combined code and supply.	Separate codes for insertion and supply.
23. Progesterone, estrogen and estrone injections diagnostic ranges	4 per recipient per any 365-day period.	Follow MA guidelines.
24. Weight management services	Prior authorization required after 5 visits; supplement is not covered.	Follow MA guidelines.
25. Annual physical	One comprehensive visit per adult per calendar year per physician.	Follow MA guidelines.
26. Infusion pump	No prior authorization required for the first 60 days. Per day reimbursement.	Follow MA guidelines.
27. Ophthalmologist Optometrist	TOS – 1 – MD TOS – J – OD	Fee schedule will be identified by provider type.

*The technical component with a hospital inpatient place code is part of the hospital DRG and will not be paid separately by the HMO.

Claims Processing Policies and Procedures

CMS 1500 Instructions

The Security Health Plan Processing System is designed to process standard health insurance claim forms (CMS 1500) using CPT-4 Procedure Codes or HCFA Common Procedure Coding System (HCPCS) with appropriate modifiers and ICD-9-CM Diagnosis Codes.

Security Health Plan Processing Systems require that a compliant red form be used. If the form is not red, it will be returned with a request for a red form.

Required information must be filled in completely, accurately, and legibly. If the information is inaccurate or incomplete, your claim cannot be processed. Instead, it will be rejected with a note explaining the rejection.

A complete claim is considered to have the following data elements (numbered as shown on claim form):

1a. Insured's ID number which includes either the subscriber number, medical history number, Social Security number and medicaid number.

2. Patient's name (last name, first, middle initial)

3. Patient's date of birth (month/day/year), and gender

4. Insured's name (last name, first, middle initial)

5. Patient's address (street, city, state, and ZIP code)

6. Patient's relationship to insured

7. Subscriber's address (if different from patient's)

8. Patient status

9. Other insured's name (last name, first name, middle initial) if applicable. Please include the actual insurance carrier name if available, not the name of a repricing company

10. If patient's condition is related to:
   – employment
   – auto accident
   – other accident

11c. Insurance plan name or program name

13. Insured's or authorized person's signature

17. Name of referring physician or other source and NPI

18. Hospitalization dates related to current services

20. Outside lab

21. Diagnosis (ICD-9-CM) or nature of illness or injury

24a. Date of service

24b. Place of service

24c. Type of service

24d. CPT/HCPCS modifier

24e. Diagnosis code

24f. Charge (for each service)

Claims Processing Policies and Procedures

24g. Days or units

24j. NPI

24k. Reserved for local use (Security Health Plan provider number)

25. Tax Identification Number (TIN)

26. Patient's account number

28. Total charge

29. Amount paid by other insurance carrier. Do not include discounts, only actual payments

31. Signature of physician or supplier

32. Name and address of facility where services were rendered (if other than home or office)

33. Physician's supplier's billing name, address, zip code, phone number and NPI

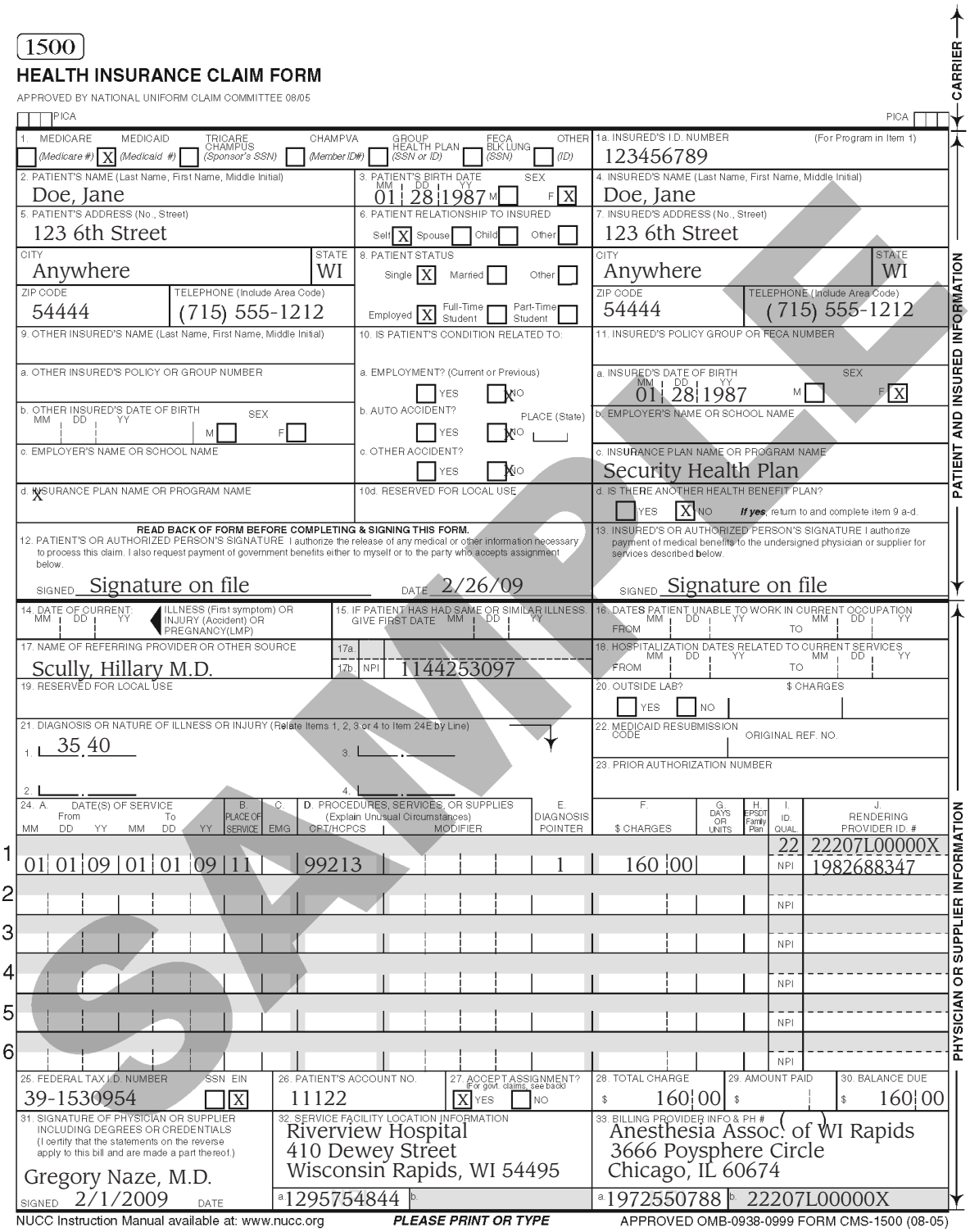
If there are any questions regarding claims submission, contact the Claims Processing Department at 1-800-548-1224.

Affiliated providers can mail claims to:

Security Health Plan
P.O. Box 8000
Marshfield, WI 54449-8000

Claims Processing Policies and Procedures

CMS 1500: Sample Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 01 28 1987 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

5. PATIENT'S ADDRESS (No., Street): 123 6th Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 6th Street

CITY: Anywhere STATE: WI

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [X] Full-Time Student [ ] Part-Time Student [ ]

CITY: Anywhere STATE: WI

ZIP CODE: 54444 TELEPHONE (Include Area Code): (715) 555-1212

ZIP CODE: 54444 TELEPHONE (Include Area Code): (715) 555-1212

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 01 28 1987 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Security Health Plan

d. INSURANCE PLAN NAME OR PROGRAM NAME: X

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on file DATE: 2/26/09

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on file

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Scully, Hillary M.D.

17a.

17b. NPI: 1144253097

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 35.40

2.

3.

4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 09	01 01 09	11		99213		1	160 00			22 NPI	22207L00000X 1982688347
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 39-1530954 [X]

26. PATIENT'S ACCOUNT NO.: 11122

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 160 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 160 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Gregory Naze, M.D.

SIGNED 2/1/2009 DATE

32. SERVICE FACILITY LOCATION INFORMATION

Riverview Hospital
410 Dewey Street
Wisconsin Rapids, WI 54495

a. 1295754844 b.

33. BILLING PROVIDER INFO & PH # ( )

Anesthesia Assoc. of WI Rapids
3666 Poysphere Circle
Chicago, IL 60674

a. 1972550788 b. 22207L00000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Claims Processing Policies and Procedures

Reimbursement Statement

Explanation of form according to line item:

1. HMO identifier
   – Advocare
   – BadgerCare Plus Program
   – Family Health Center of Marshfield, Inc.
   – Security Administrative Services
   – Security Health Plan
2. Practice name and address
3. Statement date
4. Account number assigned to the practice by Security Health Plan for reporting payments at end-of-year
5. Page number of statement
6. Date of service
7. Claim number assigned by Security Health Plan
8. Code/Description – CPT code, HCPCS code or description of service
9. Patient account – this number reflects the number supplied by the provider on the claim form
10. Charged amount
11. Provider responsibility – amounts denied to the provider
12. American National Standards Institute (ANSI) – claim adjustment reason codes for provider responsibility
13. Patient responsibility – deductibles, co-payments, coinsurance. The total amount of charges a provider is entitled to receive from the patient
14. ANSI – claim adjustment reason codes for patient responsibility
15. Reimbursement – the actual amount paid for each participant's charges
16. Patient's name
17. MHN – Medical History Number assigned to the patient by Security Health Plan
18. Subscriber number – Security Health Plan member ID number
19. Medicare credits
    – Payments to provider from Medicare
    – Fee reduction by Medicare – the difference between the billed and approved amounts on the Medicare Explanation of Benefits
    – Discount – service denied by Medicare – the discount for Security Health Plan covered services not covered by Medicare
20. Patient total – this is a summary of the charges, allowed amounts, deductibles, co-payments, coinsurance, discounts, holdback, adjusted amounts, credits, and reimbursement for each patient
21. Last statement – amount owed to Security Health Plan from prior statement activity

Explanation of form according to line item *(continued)*:

Claims Processing Policies and Procedures

22. Last payment – the amount of the previous reimbursement
23. Charge amount – the total of claim charges processed for all the patients
24. Provider responsibility – total amounts denied to the provider for this statement
25. Patient responsibility – the total amount of charges that are the patient's responsibility for this statement
26. This payment – amount of current reimbursement check
27. Provider responsibility summary – this is a list of each ANSI code with description for the entire statement. The total amount for each ANSI code is listed
28. Patient responsibility summary – this is a list of each ANSI code with description for the entire statement. The total amount for each ANSI code is listed

Claims Processing Policies and Procedures

Reimbursement Statement Sample

1 SecurityHealth Plan®
Underwritten by Security Health Plan of Wisconsin, Inc.

1515 Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
1-800-548-1224
715-221-9588

2 PROVIDER NAME
ATTN BILLING DEPT
123 E AVE
ANYTOWN, WI 00000

3 January 5, 2005 4 Account: 0-000-000 5 Page 1

6 Service Date	7 Claim Number	8 Code/Description	9 Patient Account #	10 Charged Amount	11 Provider Responsibility	12 ANSI	13 Patient Responsibility	14 ANSI	15 Reimbursement
16 **DOE, JOHN E**		17 MHN: 1111111			18 Subscriber #: 050000000000				
10/28/04	19	Fee Reduction – By Medicare			190.90	N18			190.90-
10/28/04		Payment To Affiliate – From Medicare			163.28	N9			163.28-
		Credit Subtotal			354.18				354.18-
			12345						
10/28/04	0000000	E1390-RR		395.00					395.00
		20 **Patient Totals**		**395.00**	**354.18**				**40.82**
DOE, JANE O		MHN: 2222222			Subscriber #: 050000000000				
11/26/04	0000000	92004		45.00	6.75	45			38.25
		Patient Totals		**45.00**	**6.75**				**38.25**
DEER, JON S		MHN: 3333333			Subscriber #: 050000000000				
12/09/04	0000000	92004		45.00	6.75	45	7.65	2	30.60
		Patient Totals		**45.00**	**6.75**		**7.65**		**30.60**

21 Last Statement	22 Last Payment	23 Charged Amount	24 Provider Responsibility	25 Patient Responsibility	26 This Payment
38.25-	.00	485.00	367.68	7.65	71.42

27

Provider responsibility
ANSI Code – N18 Payment based on the Medicare allowed amount.
ANSI Code – N9 Adjustment represents the estimated amount the primary payer may have paid.
ANSI Code – 45 Charges exceed your contracted/legislated fee arrangement (discount).

Total ANSI N18 =	190.90
Total ANSI N9 =	163.28
Total ANSI 45 =	13.50
Total Provider Responsibility =	367.68

28

Patient responsibility
ANSI Code – 2 Coinsurance amount

Total ANSI 2 =	7.65
Total Patient Responsibility =	7.65

Claims Processing Policies and Procedures

Correction Adjustment Request

Correction adjustment requests are required when facilities have found a charge or charges that need to be added, corrected, adjusted or deleted, as in the following examples:

- Duplicate payment
- Incorrect patient
- Incorrect date of service
- Incorrect provider
- Amount billed correction/adjustment
- Payment amount is questionable
- Credits are missing or incorrect
- Refunds
- CPT/modifier changes
- Other insurance payments/corrections (include a copy of the primary EOB)
- Specify date(s) of service involved

Corrections need to be submitted electronically on paper on a CMS 1500 claim form with "correction/ resubmission" identified in box 19. It must be received within 90 days from date of payment/denial/ rejection of original claim. Send or fax corrections/resubmissions to:

Security Health Plan
Attn: Claims Department
P.O. Box 8000
Marshfield, WI 54449-8000
Fax: 715-221-9500

Claims Processing Policies and Procedures

Security Health Plan

Correction Adjustment Request

Please check one: ☐ Security Health Plan
☐ Family Health Center
☐ SHP BadgerCare/Medicaid Managed Care

Facility name _____

Provider name _____

Provider number _____

Patient name _____

ID number _____

MHN _____ Date of service _____

Statement date _____

Requested correction _____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Authorized signature Date

Claims Processing Policies and Procedures

National Correct Coding

Security Health Plan uses the National Correct Coding matrix. This coding matrix includes both unbundled codes (procedures that describe a component of a more comprehensive procedure) billed with the more comprehensive procedure code, and mutually exclusive coding combinations. Mutually exclusive code pairs represent services or procedures that, based on either the CPT definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient.

Some specific situations that Security Health Plan will be monitoring through the use of this coding matrix are:

- Separate procedures: If provided as part of a more comprehensive procedure, separate procedure codes should not be submitted with their related and more comprehensive codes.
- Most extensive procedures: When CPT descriptors designate several procedures of increasing complexity, only the code describing the most extensive procedure actually performed should be submitted.
- "With/Without" services: Certain code descriptors designate procedures performed with or without other services. Only submit the code for the service actually performed.
- Sex designation: When code descriptors identify procedures requiring a designation for male or female, submit only the appropriate code.
- Laboratory panels: When a code for a grouping or panel of lab tests exists, bill it. Don't submit codes for individual lab tests.

Codes considered to be bundled will be denied with the ANSI codes 97 or B15.

Multiple Surgery

Reimbursement will be made as follows:

- 100% of the global fee for the procedure listed with the highest value.
- 50% of the global fee for the second through the fifth procedure.
- Each procedure after the fifth procedure will be considered on a case-by-case basis.

Exceptions to multiple procedures for a charge reduction are CPT codes, which by definition are always done and billed in conjunction with another procedure. These include codes described as "additional segments" or "second lesion."

Claims Processing Policies and Procedures

Assistants at Surgery

Assistants at surgery are covered when the assistant is considered medically necessary and appropriate. Criteria considered include the need for the expertise of another surgeon in a complicated case for decision-making or surgical involvement.

Reimbursement rate is based on the Medical Fee Schedule.

The multiple surgery reduction for subsequent procedures on the same day does apply to reimbursement for the assistant at surgery. When billing an assistant at surgery, use modifier 80 for a physician and modifier AS for a physician's assistant or nurse practitioner.

Modifiers That Require Physician Notes

The following modifiers require the physician's notes be attached to the claim:

24 – Unrelated Evaluation & Management service by the same physician during the post-op period.

79 – Unrelated procedure or service by the same physician during a post-op period.

ICD-9-CM Coding

- List the ICD-9-CM code for diagnosis, condition, problem, complaint, or other reason for the encounter or visit. Show what is chiefly responsible for the services provided.
- List up to three additional codes that describe coexisiting documented conditions that require or affect patient care, treatment or management. Do not code previously treated conditions that no longer exist.
- Verify that the diagnosis code is valid. Before submitting claims, always consult the ICD-9-CM book. Invalid diagnosis will result in claim rejection.
- Use the code at its highest level of specificity. Nonspecific diagnoses will result in claim rejection.
- Verify the diagnosis code chosen is appropriate for the gender and age of the patient.

American National Standards Institute (ANSI) Codes Claim Adjustment Reasons Code

These codes can be viewed online at *http://oci.wi.gov/pub_list/ansicode.htm.*

Bilateral Procedures

Unless otherwise identified in the listings in the CPT book, bilateral procedures that are performed at the same operative session should be identified by the appropriate five-digit code and modifier 50.

Bilateral procedures are paid based on the Medicaid Fee Schedule.

Claims Processing Policies and Procedures

High End Imaging (HEI)

Security Health Plan requires prior notification for all outpatient HEI tests: MRI, CT (excluding SPECT) and PET scans. Security Health Plan will deny high-end imaging global or professional (26 modifier) and technical service (TC modifier) claims for no prior notification.

ANSI Denial Codes Regarding HEI

- Radiology claims administratively denied for no prior notification are identified using the ANSI denial code **CO197**.
- Radiology claims administratively denied if there is prior notification but no referring provider listed on claim are identified using the ANSI denial code **CO125**(billing error) with **OAN286** remark code identifying the reason for the billing error.
- Radiology claims administratively denied if the CPT code provided for prior notification does not match the actual CPT performed are identified using the ANSI denial code **CO125 with the remark code OAN54**.

Additional HEI Claims Information

- Primary/Secondary: No notification is required when Security Health Plan is secondary to any other payer, including Medicare.
- Receipt of notification number does not guarantee payment.
- Claim questions or appeals should be submitted through the regular Security Health Plan protocol outlined in Plan Provider and Facility Manuals.
- There is no need to put the notification number on the claim form; however, the provider may do so at their discretion.
- Members may not be balanced billed for denials related to absence of prior notification for a high-end imaging procedure.

For detailed information on Security Health Plan's High-End Notification process such as frequently asked questions, specific CPT codes that require prior notification, either

a) visit Security Health Plan's main web site: www.securityhealth.org > Providers > Provider Relations Center

b) Visit Security Health Plan's online provider portal > login with your username and password; under NEW from Security Health Plan, then Announcements

Claims Processing Policies and Procedures

Coordination of Benefits

- If a member carries health insurance through more than one insurer, Security Health Plan will coordinate the benefits to ensure maximum coverage without duplication of payments.
- The affiliated provider must submit claims to the primary carrier before submitting to Security Health Plan. After a claim is submitted to the primary carrier, a claim for the balance should be submitted to Security Health Plan along with an Explanation of Benefits (EOB). The affiliated provider must submit the balance within 180 days from the date of the EOB.
- If the affiliated provider fails to comply or is unaware of the primary insurance carrier, claims for which Security Health Plan is secondary will be denied using ANSI code 22. The denial reason will print on the affiliated provider's reimbursement statement.
- If primary insurance is discovered after charges have been processed by Security Health Plan and the primary insurance makes payment, the affiliated provider may then have an overpayment. If the affiliated provider is overpaid due to primary insurance payment, the affiliated provider should complete an adjustment request form and send it along with a copy of the original claim and a copy of the EOB from the primary insurance. Claims will be reprocessed based on the primary insurance payment. The adjustment will be reflected on the affiliated provider's reimbursement statement.
- If Security Health Plan discovers a primary insurance after charges have been processed by Security Health Plan, Security Health Plan will reverse its original payment. The adjustment will be reflected on the affiliated provider's statement using ANSI 109.
- If the affiliated provider has any questions regarding coordination of benefits, please call 715-221-9503 or 1-800-548-4831, Monday through Friday between 8 a.m. and 4:30 p.m.

To assure a claim will be processed correctly and in a timely manner by Security Health Plan:

- If a Security Health Plan member has Medicare and another insurance, complete information must be on the CMS 1500 claim or UB-04 claim for the claim to be processed efficiently.
- On the CMS 1500 claim, box 11d should be checked "Yes" if there is any other insurance information. If box 11d is checked "Yes", boxes 9a – 9d on the CMS 1500 claim must be completed with the other insurance information.
- On the EB-04 claim, box 50 is completed if there is any other insurance information.
- EOBs need to accompany each CMS 1500 claim and UB-04 claim where other insurance is indicated on the claim.

Claims Processing Policies and Procedures

Order of Benefit Determination

1. **No coordination of benefits provision.** A plan automatically becomes primary if it contains no coordination of benefits provision.
2. **Employee, member or subscriber.** The benefits of a plan that covers a person as an employee, member or subscriber are determined before those of the plan that covers the person as a spouse or dependent of an employee, member or subscriber.
3. **Dependent child of parents NOT separated or divorced.** For dependent children, the benefits of the plan of the parent whose birthday falls earlier in the calendar year (month and day) are determined to be primary.

   If both parents have the same birthday, primacy is determined by which plan has the earlier effective date.
4. **Dependent child of separated or divorced parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   – First, the plan of the parent with custody.

   – Then, the plan of the spouse of the parent with custody.

   – Finally, the plan of the noncustodial parent.

   If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, the benefits of the plan of the responsible parent indicated in the court decree are determined first.

   If the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses, or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, benefits for the dependent child shall be determined according to number 3 above, the birthday rule.
5. **Subscriber under two plans.** If the subscriber is the same person under two plans, the primary plan is the one in effect the longest.
6. **Group subscriber vs. non-group.** If a group and non-group plan exist, primacy will be coordinated with the other carrier.
7. **Medical Assistance.** All private health insurance plans are considered primary. Benefits must be billed and processed prior to consideration by Medical Assistance. This applies to Security Health Plan BadgerCare Plus as well.

Claims Processing Policies and Procedures

Subrogation

- To the extent permitted by law, whenever Security Health Plan provides or pays for medical services given to a member, Security Health Plan reserves the right to recover the costs of medical services from another person, insurer, or organization found to be responsible for the cost of the services.
- Examples of occurrences which may involve subrogation include:
  - dog bites by someone else's dog
  - food poisoning
  - malpractice
  - motor vehicle accidents
  - product liability
  - slips and falls on someone else's property
- Security Health Plan will process claims first according to benefits available, then Security Health Plan will pursue subrogation against the responsible person, insurer, or organization. Security Health Plan requires the affiliated provider to submit all claims for participants, regardless if a liability insurance is involved, except if the member is Medicare eligible. When the member is Medicare eligible, the affiliated provider must follow Medicare guidelines for filing liability claims.
- When submitting claims, please indicate if accident-related.
- If the affiliated provider is overpaid due to payment from a liability insurance, the affiliated provider must send Security Health Plan a refund. An adjustment cannot be made in these cases. A check must be issued.
- If the affiliated provider has any questions regarding subrogation, please call 715-221-9503 or 1-800-548-4831 between 8 a.m. and 4:30 p.m., Monday through Friday.

Workers' Compensation

- Security Health Plan does not cover the cost of services normally covered by Workers' Compensation. Claims that are determined to be work-related will be denied using ANSI code 19. The denial reason will print on the affiliated provider's reimbursement statement. Claims must be submitted to Workers' Compensation first.
- If claims have already been paid by Security Health Plan, related charges will be reversed. The adjustment will be reflected on the affiliated provider's reimbursement statement, using ANSI 19.
- If the affiliated provider is overpaid due to payment from Workers' Compensation, the affiliated provider should complete an adjustment request form and send it along with a copy of the original claim and a copy of the EOB from Workers' Compensation. Security Health Plan will reverse charges. The adjustment will be reflected on the affiliated provider's reimbursement statement.
- If Workers' Compensation denies a claim, Security Health Plan will consider payment if a copy of the denial is attached. Security Health Plan will then pursue directly with Workers' Compensation or an attorney if one has been retained. The affiliated provider must submit within 180 days from the date on the denial.
- When submitting claims, please indicate if work related.
- If the affiliated provider has any questions regarding Workers' Compensation, please call 715-221-9503 or 1-800-548-4831, Monday through Friday between 8 a.m. and 4:30 p.m.

Claims Processing Policies and Procedures

Outside (Reference) Labs Billing Protocol

BadgerCare Plus

The outside lab has to bill the BadgerCare Plus carrier for the test(s). The clinic can bill a lab handling fee when sent to an outside lab. However, Security Health Plan BadgerCare Plus will not cover the phlebotomy fee (venipuncture) since it is bundled with the lab test. The BadgerCare Plus member cannot be billed for routine venipuncture.

When a specimen is sent to an outside lab:

- Check "Yes" in Box 20-Outside Lab on the CMS 1500 form.
- Do not bill the CPT lab code (the outside lab bills insurance carrier for it).
- Bill the handling fee (CPT 99000).
- Put the name of the outside lab in Box 19.

Additional Rules for All Outside Labs

- One lab handling fee is paid to a provider per recipient, per outside lab, per date of service, regardless of the number of specimens sent to the lab.
- More than one handling fee is paid only when specimens are sent to two or more labs for one recipient on the same date of service. Each handling fee must be billed by line item; CPT 99000 does not allow a quantity. When more than one outside lab is used, list all lab names used in Box 19.

Claims Processing Policies and Procedures

Electronic Claims

Introduction

This section of information outlines transmission media available, telecommunication specifications, testing procedures and output report feedback for electronic claims.

The Health Insurance Portability & Accountability Act (HIPAA)

HIPAA is a federal mandate passed by congress in 1996, which addresses the high administrative costs of health care. SHP is fully compliant as of October 16, 2003.

The Centers for Medicare & Medicaid Services (CMS) has been delegated authority over HIPAA Administrative Simplification provisions including Transaction & Code Set Standards. Medicare no longer accepts paper claims, with few exceptions.

HIPAA Administrative Simplification has been adopted to enable health information to be exchanged electronically, an electronic data interchange (EDI) standard, with the goals of improving the operation of the health system and reducing administrative costs.

Covered entities include health plans, clearing houses and providers. HIPAA Administrative Simplification does not mandate changes to paper transactions.

- Health plans can include, but are not limited to, Managed Care Organizations, HMOs, TPAs, ERISA plans, commercial payers, government health plans, State Medicaid agencies, and Medicare plans Part A and Part B.
- Healthcare clearinghouses may accept non-standard transactions for the purpose of translating them into standard transactions and translating standard transactions into non-standard transactions for customers.
- Providers are defined as a provider of medical or other health services and any other person furnishing health care services or supplies including, but not limited to, physicians, dentists, nursing homes, and hospitals.

An electronic transaction is the exchange of electronic information between two parties to carry out administrative or financial activities within the health care system.

The electronic transactions include the following types of information exchanges:

- Institutional Health Care Claim – 837
- Professional Health Care Claim – 837
- Dental/ADA Claim – 837
- Health Care Remittance Advice – 835
- Eligibility for a Health Plan Request and Response – 270/271
- Health Care Claim Status Request and Notification – 276/277
- Referral Authorization 278 – Health Care Services Review

The ANSI ASC X12N Subcommittee, with a few exceptions, is the developer of the transactions. These transactions are in the 4010 version of the ASC X12N standard.

Claims Processing Policies and Procedures

Electronic Claims *(continued)*

Code sets are a standard method of identifying, classifying and describing something such as conceptual or physical attributes of persons, places or things. Code sets are used to identify providers, employers, health plans, and beneficiaries or enrollees; diagnoses, medical procedures, pharmaceuticals; and other characteristics of patients, providers or services. Generally a code set consists of numerical or alpha-numeric codes and an associated description. Code sets define the valid data that can be used within a transaction.

Included in the HIPAA compliant transactions are the following Medical Data Code Sets:

- ICD-9, Volumes 1 and 2, as maintained and distributed by HHS
- The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association, for physician services and other health care services
- National Drug Codes (NDC), as maintained and distributed by HHS for drugs and biologics
- Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association for dental procedures

Wisconsin SHFS HIPAA-related publications, a list of HIPAA acronyms, and other valuable HIPAA information can be found at *http://www.dhfs.state.wi.us/hipaa/*

A provider may choose to submit claims to clearinghouses or may choose to submit electronic claims directly to SHP. Claim files will be accepted in 4010 format.

The intent is to make the conversion from paper claims to electronic claims submission as easy as possible. If any procedures or requirements of the system as outlined in this section are not acceptable, please contact Security Health Plan to try to develop an alternative.

Electronic File Submission Process

Does your software already create the HIPAA 837 format for electronic claims?

- If yes, Security Health Plan can accept your claims directly.
- If no, Security Health Plan cannot accept your claims directly – you will need to obtain 837 software; SHP does not provide or assist with 837 software. We recommend you contact a clearinghouse for assistance (example: *http://www.mcps-inc.com/*).

Providers interested in submitting electronic claim transactions directly to Security Health Plan should visit the Security Health Plan Web site at *www.securityhealth.org* and click on the *Providers* link, then *Forms Library*. Choose the *837/835 Enrollment Request* form and mail or fax to the address noted on the form. Upon setup completion, the submitter will be notified of the username and password.

File naming standards

- 6-character name plus a 3-character extension complying with the following standards:
  - first character is D
  - second through sixth characters are your submitter ID
  - 3-character extension will be
    tst = if this is a test file
    dat = if the data is not compressed, production file
    zip = if the data is compressed (with PKZIP or compatible compression), production file

Claims Processing Policies and Procedures

Testing Procedures

Once the username and password are assigned, the submitter can start sending claim transactions to the test environment. The test file may include any number of claims. Generally, trying to parallel a production run will yield the best test results. During the testing process, SHP will examine submitted test transactions for required elements, and will also ensure that the submitter gets a response during the testing mode. SHP will notify the provider upon the successful completion of testing.

When the submitter is ready to send an 837 transaction to the production mailbox, he/she must notify IS-SHP Development at 715-221-8340, and IS-SHP Development will move the submitter to the production environment. The submitter's FTP username remains the same when moving from test to production. Passwords can be changed by the user in Personal Properties.

To submit a claim file:

- Go to the Security Health Plan website at the address *http://www.securityhealth.org*
- Single click on "File Transfers"
- Select *BBS Login* and single click on connection method
- A dialogue box will appear on the Web Browser entitled "Connect to bbs1.marshfieldclinic.org". Enter in the username and password assigned by Security Health Plan.
- After entry of username and password, single click "OK" or hit enter
- Single click "File Libraries"

The file transfer page will appear. To send a file:

- Single click "Upload"
- Browse or type the file to be sent
- Single click "Upload Now"

To look at response reports:

- Single click "All files"
- Select the report to look at
- The reports will be available for 30 days
- The last response will not have a time stamp

Personal Properties can be changed and updated from the home page to reflect information such as address and company information. Also in Personal Properties the following information is displayed: messages written, number of calls, user date, last call, last new fields, downloads, uploads, expire date, account balance, and netmail balance. Personal Properties is where passwords can be changed and messaging data can be changed and updated.

Claims Processing Policies and Procedures

Output Reports

With each production file submitted electronically, a report will be produced. This report will include the total number of claims processed. Please verify this number is correct for each report.

A second report is produced if patient demographics submitted on the claim do not match the database when Security Health Plan believes its information is correct. These demographics are the insured's ID, date of birth, gender, and relationship to insured. Information that needs to be corrected will appear as a mismatch report.

These reports can be retrieved from Security Health Plan's bulletin board system electronically the next day after the file has been sent. The response file will have an "R" preceding the file name.

Security Health Plan Companion Document

Segment	Field	Description	What we need
ISA	08	Interchange receiver ID	Submitter ID including preceding zeroes (ie. 000055001)
ISA	15	Usage indicator	Must be "T" for a test file, "P" for production
GS	03	Application receiver's code	Submitter ID including preceding zeroes
Submitting info NM1	09	(NM101 = 41) Identification code	Submitter ID including preceding zeroes
Receiver info NM1	09	(NM101 = 40) Identification code	"SHP"